



38 CFR Part 17

RIN 2900-AQ69

Billing and Collection by VA for Medical Care and Services

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with nonsubstantive changes, a proposed rule to revise its regulations concerning collection and recovery by VA for medical care and services provided to an individual for treatment of a nonservice-connected disability. Specifically, this rulemaking will revise the provisions of VA regulations that determine the charges VA will bill third-party payers for non-VA care provided at VA expense, will include a time limit for which third-party payers can request a refund, and will clarify that third-party payers cannot reduce or refuse payment because of the billing methodology used to determine the charge.

DATES: This rule is effective on [insert date that is 30 days after date of publication in the FEDERAL REGISTER].

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Office of Community Care (10D), Veterans Health Administration, Department of Veterans Affairs, Ptarmigan at Cherry Creek, Denver, CO, 80209; (303) 372-4629. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Under section 1729 of Title 38, United States Code (U.S.C.), VA has the right to recover or collect reasonable charges for medical care or services from a third party to the extent that the veteran or the provider of the care or services would be eligible to receive payment from the third party for: a nonservice-connected disability for which the veteran is entitled to care (or the payment of expenses of care) under a health plan contract; a nonservice-connected disability incurred incident to the veteran's employment and covered under a worker's

compensation law or plan that provides reimbursement or indemnification for such care and services; or a nonservice-connected disability incurred as a result of a motor vehicle accident in a State that requires automobile accident reparations (no-fault) insurance.

On October 28, 2019, VA published a proposed rule to revise the methodology in 38 CFR 17.101 with regards to how VA calculates reasonable charges for purposes of billing third parties when medical care was provided at a non-VA facility at VA expense. Specifically, that rule proposed calculating these charges in the same manner as if the care and services had been provided in VA facilities. See 84 FR 57668. That proposed rule additionally sought to make several technical amendments to § 17.101, to correct clerical errors, update office and data source names, add two new definitions, and remove one current definition to be consistent with the proposed technical amendments. Lastly, the proposed rule sought to revise § 17.106 to clarify the timeframe for submitting a written request for a refund for claims under 38 U.S.C. 1729, further explaining that VA would not provide a refund for any reason, to include if a retroactive service-connection determination is made more than 18 months after the date payment is made by the third-party payer, and adding a new condition under which a third-party payer could not refuse or reduce their payment for a claim under section 1729.

VA received five comments in response to the proposed rule, some of which supported the proposed rule and requested clarifications and some of which suggested changes to provisions in the proposed rule. For the reasons stated below, we adopt the proposed rule as final with minor nonsubstantive changes.

One comment expressed support for the rule because it would establish additional safeguards to ensure that third-party insurance payers could not reject VA's requests for payment due to disagreements with administrative issues such as billing

methods. This comment did not suggest any changes to the proposed regulatory revisions, and we do not make changes based on this comment.

Two comments expressed support for the proposed rule but also requested clarification of how VA will treat third-party payments for non-VA care for veterans that do not have private health insurance, with one comment more specifically requesting clarification of whether uninsured veterans will be responsible for payment of the same non-VA care that third-party insurers are responsible for under the proposed rule. We clarify that veterans without private health insurance would not be responsible for the cost of non-VA care where such veterans are otherwise eligible for VA to pay for such care, for instance, if such veterans were eligible to receive care or services through the Veterans Community Care Program pursuant to 38 U.S.C. 1703 and 38 CFR 17.4000 et seq. The same comment that specifically requested clarification of a veteran's financial responsibility where they have no private health insurance also expressed concern that, if veterans without private health insurance were not financially responsible for the cost of non-VA care, then VA may create an incentive for veterans to drop their other private health insurance. The rationale for this statement in the comment was that where a veteran is privately insured, the VA benefit to cover non-VA care is non-existent, and because a majority of private insurers impute some level of cost-sharing, it would be more economical for veterans to simply not be privately insured. Although this comment is beyond the scope of the proposed rule (as § 17.101 has long implemented VA's authority under 38 U.S.C. 1729 to collect from third-party insurers for the costs of care furnished or paid for by VA, this was not a new change in the proposed rule), we will correct some misstatements from the comment to provide a more full response. We first correct the statement from the comment that where a veteran is privately insured, the VA benefit to cover non-VA care is non-existent—VA's legal authority to furnish non-VA care, such as care furnished pursuant to 38 U.S.C. 1703 and 38 CFR 17.4000 et

seq., is controlled outside of VA's authority to collect from third-party insurers under section 1729, and VA's provision of non-VA care is not dependent on whether a veteran has private health insurance. We also correct the potential misunderstanding that veterans without private health insurance would be free from cost-sharing responsibilities where VA pays for the provision of non-VA care, such veterans may be subject to VA copayments as applicable. We do not make changes based on these comments.

One comment requested clarification of the proposed 18-month limitation to seek a refund from VA that would be established in § 17.106(c)(4), and whether a non-VA provider could seek such a refund from a veteran if the non-VA provider missed the 18-month window in which to seek a refund from VA. This comment further suggested including a rule to protect veterans from non-VA providers seeking refunds from veterans after the 18-month window. We clarify that the proposed regulatory changes would not establish a billing or payment relationship between a veteran and a non-VA provider or entity, as current § 17.106(c)(4) and the proposed revision both relate to only the relationship between a third-party payer and VA in instances where VA has collected for the cost of nonservice-connected care provided in or through a VA facility where a veteran has private health insurance. The proposed 18-month timeframe would limit the amount of time a third-party insurance payer may seek a refund from VA, where VA has billed that insurer for nonservice-connected, and the insurer has assessed that it has overpaid VA for that care. As such, current § 17.106 and the revisions as proposed do not establish any payment relationship between a non-VA provider and a Veteran, and we otherwise reiterate from earlier in this preamble that veterans would not be responsible for the cost of non-VA care where such veterans are otherwise eligible for VA to pay for such care, except to the extent there may be

applicable copayments for such care. We do not make changes based on this comment.

One comment raised multiple issues related to the proposed rule. The comment first asserted that the proposed rule would implement non-standard third-party billing and collection processes that have the potential to impact VA's efforts to create and maintain an integrated delivery system with community care. The comment more specifically stated that VA's practice of billing the higher of the charges determined pursuant to § 17.101 or the amount paid to the non-VA provider is unique to VA, inconsistent with industry practice, and unnecessarily puts VA into a payment and billing process when veterans with other health insurance receive nonservice-connected care from non-VA providers. We agree with the portion of the comment that the higher of language in § 17.101(a)(7) has presented challenges because it is not the industry standard practice, which is why we proposed to remove that language so that § 17.101 would provide that reasonable charges would be calculated only using the methodology set forth in § 17.101. To address the concern in this portion of the comment related to additional administrative burden for VA and for third-party payers, we reiterate from the proposed rule that removing the higher of language in § 17.101(a)(7) will reduce administrative burden by permitting VA to bill the rate determined using the methodologies set forth in § 17.101 (those methodologies that calculate charges as if the care was provided at a VA facility), which will provide greater clarity and uniformity in VA's billing practices. Revising § 17.101(a)(7) such that VA charges the same rate regardless of whether the care was provided at a VA facility or a non-VA facility at VA expense will cut down on the administrative burden associated with determining the charges. 84 FR 57668, 57669. We also reiterate from the proposed rule that it is equitable to charge the same rates regardless of the facility in which the individual sought treatment, and the proposed revision is beneficial to the third-party payer as

there is no scenario in which the third-party payer would be charged more under the proposed rule than they are charged under the current rule. 84 FR 57668, 57669. We believe the other statements in this portion of the comment similarly misread other changes being made in the proposed rule, and mistook that VA is not the first-party payor with regards to the non-VA care discussed in the proposed rule. We clarify that where VA is otherwise responsible for furnishing care to veterans, and such veterans are eligible to receive non-VA care in the community, VA remains the first party payer and is authorized under 38 U.S.C. 1729 to bill and collect reasonable charges for nonservice-connected care where such veterans have other private health insurance. Therefore, the proposed rule does not create a non-standard third-party billing and collection process when veterans with other health insurance receive nonservice-connected care from non-VA providers at VA expense. We do not make changes based on this portion of the comment.

The comment next asserted that the proposed rule may result in the amounts that VA collects from third-party insurers for non-VA care furnished in the community being significantly more than what VA pays non-VA providers to furnish such care. In support of this statement, the comment more specifically noted that there is a discrepancy between: the methodology outlined in 38 CFR 17.101 where charges are weighted at the 80th percentile of nationwide charges; and VA's payments of applicable Medicare fee schedules or prospective payment system amounts for non-VA care in the community, where the comment asserted that such Medicare rates were weighted at approximately 23 percent of nationwide charges. This portion of the comment also noted that the pricing methodologies in § 17.101 needed to be generally reviewed to incorporate the price transparency requirements of the Affordable Care Act and other efforts related to price transparency undertaken by the Centers for Medicare and Medicaid Services, as well as to be consistent with VA's efforts to conduct market cost

assessments under section 106 of Public Law 115-182. Ultimately, we believe that this portion of the comment is beyond the scope of the proposed rule, as § 17.101 has long established use of the 80th percentile of nationwide charges in a number of its methodologies, and this was not a new change in the proposed rule.

Similarly, the proposed rule did not raise the issue of VA's payment to non-VA providers for the furnishing of care in the community, or how VA authorizes the provision of such care; rather, the rulemaking concerned how VA bills third parties. Nor did the proposed rule raise more general review of the reasonable charges methodologies in § 17.101 at large. However, we generally respond to this portion of the comment that VA's payment to non-VA providers for care furnished in the community is controlled by 38 U.S.C. 1703(i) and 38 CFR 17.4035. Such payments are not impacted by what VA bills to third party payers for non-VA care where veterans have private health insurance under section 1729 and § 17.101. Payments for care in the community and billing of third-party payers for non-VA care are distinct from one another and conducted pursuant to distinct statutory and regulatory authorities. We also do not see any link between VA's conducting of market analyses under section 106 of Public Law 115-182 and VA's reasonable charge methodologies in § 17.101. We do not make any changes based on this portion of the comment.

The comment next expressed concern regarding the proposed addition of new § 17.106(f)(2)(viii) to state that a provision in a third-party payer's plan that directs payment for care or services be refused or lessened because the billing is not presented in accordance with a specified methodology (such as a line item methodology) is not by itself a permissible ground for refusing or reducing third-party payment of the charges billed by VA. The comment asserted that VA's example of its per diem billing methods as being different from some third-party insurer's line item methods was not a sufficient rationale for this revision, and further that VA's per diem

methodology would result in bundled billing practices that could leave third-party insurers in the position to be charged and pay for service-connected care as well as nonservice-connected care. VA's example of its per diem billing methodologies as provided in the proposed rule is only one type of practice that may differ from third-party billing practices, although we reiterate that even this one example is sufficient rationale to support the proposed revision of § 17.106(f)(2) because this difference in billing methodologies has resulted in some third-party payers refusing to pay part or all of the charges for VA care or medical services. When a third-party payer's plan has provisions that have the effect of excluding from coverage or limited payment for certain care if such care is provided in or through any VA facility, VA is authorized under 38 U.S.C. 1729(f) to implement measures to ensure that such provisions do not operate to prevent collection by the United States. 84 FR 57668, 57674. Regarding the statement in this portion of the comment related to bundling of services in VA's per diem methodologies, we clarify that VA's per diem methodologies do not provide for the comingling of billing charges for both nonservice-connected care and service-connected care, as 38 U.S.C. 1729 only permits assessment for reasonable charges for nonservice-connected care. We do not make changes based on this portion of the comment.

VA makes multiple nonsubstantive changes from the proposed rule, none of which are based on public comment. First, VA replaces the term Optum Essential every time it was proposed to appear in § 17.101 (see 84 FR 57668, 57670) with the term Medicare ASP Pricing. This change is required because the Optum Essential data set has become unavailable to VA since publication of the proposed rule. Similar to Optum Essential, the Medical ASP Pricing data set is a longstanding and publicly available dataset associated with Centers for Medicare and Medicaid Billing, with similar data elements. Next, VA renumbers § 17.106(f)(2)(viii) as proposed to § 17.106(f)(2)(ix) in this final rule, to correct a discrepancy in drafting with another recently published VA

rulemaking (AQ68), where AQ68 has already added a new § 17.106(f)(2)(viii) (see 85 FR 53173). We also correct an inadvertent omission of language from § 17.101(f)(3) as proposed, related to explanation in paragraph (f)(3) that CPT/CHPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPSC code group. This explanatory language existed in § 17.101(f)(3) prior to the proposed rule and was followed by additional parenthetical explanation that the selected CPT/HCPSC codes are set forth in the Milliman USA, Inc., Health Cost Guidelines fee survey. When we proposed to change the term “Milliman USA, Inc.” to “Milliman, Inc.” in § 17.101(f)(3), we failed to transcribe the additional explanatory language as described above, and now correct that error by reinserting in paragraph (f)(3) language that representative CPT/CHPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPSC code group (the selected CPT/HCPSC codes are set forth in the Milliman, Inc., Health Cost Guidelines fee survey). We correct a similar omission in § 17.101(i)(3) as proposed, to now reinsert parenthetical language that “(the selected CPT/HCPSC codes are set forth in the Milliman, Inc., Health Cost Guidelines fee survey).” We additionally correct a similar omission in § 17.101(l)(3) as proposed to now reinsert language related to Milliman data sets, to read “; and Milliman, Inc., Optimized HMO (Health Maintenance Organization) Data Sets (see paragraph (a)(3) of this section for Data Sources).”

For the reasons stated in the preamble of this rule, VA makes nonsubstantive changes from the proposed rule.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select

regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is not a significant regulatory action under Executive Order 12866.

VA's regulatory impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's website at <http://www.va.gov/orpm> by following the link for VA Regulations Published from FY 2004 through FYTD.

Regulatory Flexibility Act

The Secretary hereby certifies that this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. We identified that 400 out of 745 third-party payers would qualify as small entities pursuant to the revenue threshold established by NAICS code 524114 (Direct Health and Medical Insurance Carriers) to be affected by changes in §17.101 of this rule. The number of 400 was derived by assuming potential effects on all entities that fell below the applicable revenue threshold, without further numeric breakout. Although this 400 number is greater than 1 percent of the 745 total entities, the changes in § 17.101 of this rule do not impose any new requirements that create a significant economic impact, as these changes do not result in new or changed fees or significant changes in any permissible charges. The changes made in § 17.101 related

to revising, adding, or removing definitions are technical in nature and conform to existing statutory requirements and existing practices in the program. Similarly, the change made in § 17.101 related to only using the reasonable charges methodology set forth in 17.101 conforms to existing statutory authority and is the clearer and more uniform calculation method, which will not require any additional training for the small entities to understand.

We further identified that 39 out of 745 third-party payers would qualify as small entities pursuant to the revenue thresholds established by NAICS code 524114 (Direct Health and Medical Insurance Carriers) to be affected by changes in § 17.106 of this rule related to the 18-month timeframe in which to submit a request for a refund. The number 39 was derived from VA's examination of its Consolidated Patient Account Center (CPAC) data pertaining to the amount of refund requests received in fiscal year 2019 where such requests were received after 18 months. We believe this number 39 is appropriate for the specific change in § 17.106 (versus the more general 400 number for the changes in § 17.101) because it is our experience that entities generally do not wish to wait as long as or beyond 18 months to submit refund requests. Although this 39 number is greater than 1 percent of the 745 total entities, the average impact on such small entities would be \$385 per entity (based on VA's examination of its fiscal year 2019 CPAC data), which also will not create a significant economic impact. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the

aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Although this rule contains a provision constituting a collection of information, at 38 CFR 17.101, no new or modified collections of information are associated with this rule. The information collection provision for § 17.101 is currently approved by the Office of Management and Budget (OMB) and has been assigned OMB control number 2900-0606.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. § 801 et seq.), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. § 804(2).

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.008, Veterans Domiciliary Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.029—Purchase Care Program; 64.033—VA Supportive Services for

Veteran Families Program; 64.034—VA Grants for Adaptive Sports Programs for Disabled Veterans and Disabled Members of the Armed Forces; 64.035—Veterans Transportation Program; 64.039—CHAMPVA; 64.040—VHA Inpatient Medicine; 64.041—VHA Outpatient Specialty Care; 64.042— VHA Inpatient Surgery; 64.043—VHA Mental Health Residential; 64.044— VHA Home Care; 64.045—VHA Outpatient Ancillary Services; 64.046—VHA Inpatient Psychiatry; 64.047—VHA Primary Care; 64.048—VHA Mental Health clinics; 64.049—VHA Community Living Center; 64.050—VHA Diagnostic Care.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign Relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Reporting and recordkeeping requirements, Scholarships and fellows, Travel, Transportation expenses, Veterans.

Signing Authority

The Secretary of Veterans Affairs approved this document on March 12, 2021 and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

Regulations Development Coordinator,
Office of Regulation Policy & Management,
Office of the Secretary,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17--MEDICAL

1. The general authority citation for part 17 continues, and an entry for § 17.101 is added in numerical order, to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

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Section 17.101 is also issued under 38 U.S.C. 101, 1701, 1705, 1710, 1721, 1722, 1729.

* * * * *

2. Amend 17.101 as follows:

a. In paragraph (a)(5), add definitions for “FAIR Health” and “MarketScan” in alphabetical order and remove the definition of “MDR”;;

b. Revise paragraphs (a)(7), (f)(2)(ii), (f)(3) introductory text, (h)(2) introductory text, (h)(2)(i) and (ii), (h)(3), (i)(2)(ii), (i)(3) introductory text, (l)(3) introductory text, and (l)(3)(ii); and

c. In the following table, for each paragraph indicated in the left column, remove the words indicated in the middle column from wherever it appears in the paragraph, and add in their place the words indicated in the right column.

Paragraph	Remove	Add
(a)(2) and (3)	Chief Business Office	Office of Community Care

(a)(2) and (3)	http://www.va.gov/cbo , under “Charge Data.”	https://www.va.gov/COMMUNITYCARE , under “Payer Rates and Charges.”
(l)(2)(i)(A), (B), and (M)	Ingenix/St. Anthony’s	Medicare ASP Pricing
(e)(3)(ii), (e)(4), (g)(3)(i), (i)(2)(i), (l)(2)(iii), (l)(5)(ii)	MDR	FAIR Health
(b)(2) introductory text, (b)(3), (e)(3)(ii)	MedStat	MarketScan
(e)(4), (g)(3)(i), (l)(5)(iii)	Milliman USA, Inc.	Milliman, Inc.
(d)(2) introductory text, (e)(3)(i) introductory text, (e)(3)(i)(A) and (B), (e)(3)(ii), (f)(4), (g)(3)(i), (j)(2)(i), (k)(2)(i) and (ii), (l)(5)(ii)	percent Sample	Percent Sample
(e)(3)(i)(C)	2.0	6.5
(e)(3)(i)(C)	6.5	2.0

The additions and revisions read as follows:

**§ 17.101 Collection or recovery by VA for medical care or services provided or
furnished to a veteran for a nonservice-connected disability.**

* * * * *

(a) * * *

(5) * * *

FAIR Health means any of the Fair Health Charge Benchmarks products developed by Fair Health.

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MarketScan means the MarketScan Commercial Claims & Encounters Database developed by Truven Health Analytics LLC.

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(7) *Charges for medical care or services provided by non-VA providers at VA expense.* When medical care or services are furnished at the expense of the VA by non-VA providers, the charges billed for such care or services will be the charges determined according to this section.

* * * * *

(f) * * *

(2) * * *

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraph (f)(2)(i) or (iii) of this section, total RVUs are developed based on various charge data sources. For these CPT/HCPCS codes, that nationwide 80th percentile billed charges are obtained, where statistically credible, from the FAIR Health database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 Percent Sample. For each of these CPT/HCPCS codes, nationwide total RVUs are obtained by taking the nationwide 80th percentile billed charges obtained using the preceding databases and dividing by the nationwide conversion factor for the corresponding CPT/HCPCS code group determined pursuant

to paragraphs (f)(3) introductory text and (f)(3)(i) of this section. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Medicare ASP Pricing RBRVS. The resulting nationwide total RVUs obtained using these data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (f)(2)(iv) of this section to obtain the area-specific total RVUs.

* * * * *

(3) *Geographically-adjusted 80th percentile conversion factors.* CPT/HCPCS codes are separated into the following 23 CPT/HCPCS code groups: allergy immunotherapy, allergy testing, cardiovascular, chiropractor, consults, emergency room visits and observation care, hearing/speech exams, immunizations, inpatient visits, maternity/cesarean deliveries, maternity/non-deliveries, maternity/normal deliveries, miscellaneous medical, office/home/urgent care visits, outpatient psychiatry/alcohol and drug abuse, pathology, physical exams, physical medicine, radiology, surgery, therapeutic injections, vision exams, and well-baby exams. For each of the 23 CPT/HCPCS code groups, representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman, Inc., Health Cost Guidelines fee survey); see paragraph (a)(3) of this section for Data Sources. The 80th percentile charge for each selected CPT/HCPCS code is obtained from the FAIR Health database. A nationwide conversion factor (a monetary amount) is calculated for each CPT/HCPCS code group as set forth in paragraph (f)(3)(i) of this section. The nationwide conversion factors for each of the 23 CPT/HCPCS code groups are trended forward to the effective time period for the charges, as set forth in paragraph (f)(3)(ii) of this section. The resulting

amounts for each of the 23 groups are multiplied by geographic area adjustment factors determined pursuant to paragraph (f)(3)(iii) of this section, resulting in geographically-adjusted 80th percentile conversion factors for each geographic area for the 23 CPT/HCPCS code groups for the effective charge period.

* * * * *

(h) * * *

(2) *Nationwide 80th percentile charges by HCPCS code.* For each HCPCS dental code, 80th percentile charges are extracted from various independent data sources, including the National Dental Advisory Service nationwide pricing index and the Dental FAIR Health module (see paragraph (a)(3) of this section for Data Sources). Charges for each database are then trended forward to a common date, based on actual changes to the dental services component of the CPI-U. Charges for each HCPCS dental code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (h)(2)(i) of this section. HCPCS dental codes designated as unlisted are assigned 80th percentile charges by means of the methodology set forth in paragraph (h)(2)(ii) of this section. Finally, the resulting amounts are each trended forward to the effective time period for the charges, as set forth in paragraph (h)(2)(iii) of this section. The results constitute the nationwide 80th percentile charge for each HCPCS dental code.

(i) *Averaging methodology.* The average charge for any particular HCPCS dental code is calculated by first computing a preliminary mean of the available charges for each code. Statistical outliers are identified and removed. In cases where none of the charges are removed, the average charge is calculated as a mean of all reported charges.

(ii) *Nationwide 80th percentile charges for HCPCS dental codes designated as unlisted procedures.* For HCPCS dental codes designated as unlisted procedures, 80th

percentile charges are developed based on the weighted median 80th percentile charge of HCPCS dental codes within the series in which the unlisted procedure code occurs. A nationwide VA distribution of procedures and services is used for the purpose of computing the weighted median.

* * * *

(3) *Geographic area adjustment factors.* A geographic adjustment factor (consisting of the ratio of the level of charges in a given geographic area to the nationwide level of charges) for each geographic area and dental class of service is obtained from Milliman Inc., Dental Health Cost Guidelines, a database of nationwide commercial insurance charges and relative costs; and a normalized geographic adjustment factor computed from the Dental FAIR Health module, as follows: Using local and nationwide average charges reported in the FAIR Health database, a local weighted average charge for each dental class of procedure codes is calculated using utilization frequencies from the Milliman Inc., Dental Health Cost Guidelines as weights (see paragraph (a)(3) of this section for Data Sources). Similarly, using nationwide average charge levels, a nationwide average charge by dental class of procedure codes is calculated. The normalized geographic adjustment factor for each dental class of procedure codes and for each geographic area is the ratio of the local average charge divided by the corresponding nationwide average charge. Finally, the geographic area adjustment factor is the arithmetic average of the corresponding factors from the data sources mentioned in the first sentence of this paragraph (h)(3).

(i) * * *

(2) * * *

(ii) *RVUs for CPT/HCPCS codes that do not have Medicare-based RVUs and are not designated as unlisted procedures.* For CPT/HCPCS codes that are not assigned RVUs in paragraphs (i)(2)(i) or (iii) of this section, total RVUs are developed

based on various charge data sources. For these CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the FAIR Health database. For any remaining CPT/HCPCS codes, the nationwide 80th percentile billed charges are obtained, where statistically credible, from the Part B component of the Medicare Standard Analytical File 5 Percent Sample. For any remaining CPT/HCPCS codes that have not been assigned RVUs using the preceding data sources, the nationwide total RVUs are calculated by summing the work expense and non-facility practice expense RVUs found in Medicare ASP Pricing RBRVS. The resulting nationwide total RVUs obtained using these data sources are multiplied by the geographic area adjustment factors determined pursuant to paragraph (i)(2)(iv) of this section to obtain the area-specific total RVUs.

* * * * *

(3) *Geographically-adjusted 80th percentile conversion factors.* Representative CPT/HCPCS codes are statistically selected and weighted so as to give a weighted average RVU comparable to the weighted average RVU of the entire pathology/laboratory CPT/HCPCS code group (the selected CPT/HCPCS codes are set forth in the Milliman, Inc., Health Cost Guidelines fee survey). The 80th percentile charge for each selected CPT/HCPCS code is obtained from the FAIR Health database. A nationwide conversion factor (a monetary amount) is calculated as set forth in paragraph (i)(3)(i) of this section. The nationwide conversion factor is trended forward to the effective time period for the charges, as set forth in paragraph (i)(3)(ii) of this section. The resulting amount is multiplied by a geographic area adjustment factor determined pursuant to paragraph (i)(3)(iv) of this section, resulting in the geographically-adjusted 80th percentile conversion factor for the effective charge period.

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(l) * * *

(3) *Nationwide 80th percentile charges for HCPCS codes without RVUs.* For each applicable HCPCS code, 80th percentile charges are extracted from two independent data sources: the FAIR Health database and the combined Part B and DME components of the Medicare Standard Analytical File 5 Percent Sample; and Milliman, Inc., Optimized HMO (Health Maintenance Organization) Data Sets (see paragraph (a)(3) of this section for Data Sources). Charges from each database are then trended forward to the effective time period for the charges, as set forth in paragraph (l)(3)(i) of this section. Charges for each HCPCS code from each data source are combined into an average 80th percentile charge by means of the methodology set forth in paragraph (l)(3)(ii) of this section. The results constitute the nationwide 80th percentile charge for each applicable HCPCS code.

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(ii) *Averaging methodology.* The average 80th percentile trended charge for any particular HCPCS code is calculated by first computing a preliminary mean of the available charges for each HCPCS code. Statistical outliers are identified and removed. In cases where none of the charges are removed, the average charge is calculated as a mean of all reported charges.

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4. Amend § 17.106 by revising paragraph (c)(4) and adding paragraph (f)(2)(ix) to read as follows:

§ 17.106 VA collection rules; third-party payers.

* * * * *

(c) * * *

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any

payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted within 18 months from the original payment date and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part. If third-party payers do not submit requests for a refund within this 18-month time frame, VA will not provide a refund to third-party payers for a paid claim for any reason.

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(f) * * *

(2) * * *

(ix) A provision in a third-party payer's plan that directs payment for care or services be refused or lessened because the billing is not presented in accordance with a specified methodology (such as a line item methodology) is not by itself a permissible ground for refusing or reducing third-party payment.

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